

MDR Tracking Number: M5-05-0745-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-02-04.

The requestor has withdrawn dates of service 3-5-04 and 5-14-04. These services will not be a part of this review.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The neuromuscular reeducation, therapeutic exercises, therapeutic activities and manual therapy technique from 11-03-03 through 11-12-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-28-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 97112 for date of service 11-14-03, 11-17-03, 11-19-03, 11-21-03 and 11-24-03 was denied on the EOB which shows an audit date of **12-30-03** with an F – reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts. The adjustor recommended that the MAR be paid. The recommended reimbursement (MAR) was reflected in the "Total Allowance" column of the EOB. The requestor states that no payment was received from the insurance carrier for these dates of service. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$167.05 (\$33.41 x 5 DOS).**

CPT code 97530 for date of service 11-14-03, 11-17-03, 11-19-03, 11-21-03 and 11-24-03 was denied on the EOB which shows an audit date of **12-30-03** with an F – reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts. The adjustor recommended that the MAR be paid. The recommended reimbursement (MAR) was reflected in the “Total Allowance” column of the EOB. The requestor states that no payment was received from the insurance carrier for these dates of service. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$329.60 (\$65.92 x 5 DOS).**

CPT code 97140 for date of service 11-14-03, 11-17-03, 11-19-03, 11-21-03 and 11-24-03 was denied on the EOB which shows an audit date of **12-30-03** with an F – reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts. The adjustor recommended that the MAR be paid. The recommended reimbursement (MAR) was reflected in the “Total Allowance” column of the EOB. The requestor states that no payment was received from the insurance carrier for these dates of service. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$309.00 (\$61.80 x 5 DOS).**

CPT code 99212-25 for date of service 11-14-03, 11-17-03, 11-19-03, 11-21-03 and 11-24-03 was denied on the EOB which shows an audit date of **12-30-03** with an F – reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts. The adjustor recommended that the MAR be paid. The recommended reimbursement (MAR) was reflected in the “Total Allowance” column of the EOB. The requestor states that no payment was received from the insurance carrier for these dates of service. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of \$209.55 (\$41.91 x 5 DOS).**

CPT code 97110 for date of service 11-14-03, 11-17-03, 11-19-03, 11-21-03 and 11-24-03 was denied on the EOB which shows an audit date of **12-30-03** with an F – reimbursement has been calculated according to the state fee schedule guidelines or relative and actual charge data amounts.

Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

This Finding and Decision is hereby issued this 10th day of March 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 11-3-03 through 11-24-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 10th day of March 2005.

Margaret Ojeda, Manager, Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

MO/da

Enclosure: IRO decision

February 9, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-0745-01
TWCC #:
Injured Employee:
Requestor: Cotton D. Merritt, D.C.
Respondent: Broadspuire o/b/o America Motorists Insurance
MAXIMUS Case #: TW04-0532

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on _____. The patient reported that while at work she began to experience low back pain while mopping. An MRI performed on 3/2/00 was reported to have shown an anterior and posterior annular bulge at L3-L4. Initially, the patient had been treated with medications, physical therapy, chronic rehabilitation, pain management and work hardening. Subsequently the patient underwent an IDET procedure on 2/8/02. On 11/7/02, the patient underwent a lumbar fusion followed by pain management. In September 2003, the patient was released to begin a postoperative rehabilitation program. Postoperative treatment included therapeutic activities, active and passive stretching, neuromuscular reeducation, and manual therapies. Current diagnoses for this patient include lumbar intervertebral disc disorder without myelopathy and failed low back surgery.

Requested Services

Neuromuscular reeducation, therapeutic exercises, therapeutic activities, and manual therapy technique, from 11/3/03 – 11/12/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. History of Presenting Illness 2/12/02
2. FCE 2/17/03
3. Chart Notes 9/8/03 – 12/6/04
4. EMG report 6/22/04
5. Operative Notes 11/7/02, 11/13/01, 3/23/04
6. NCV/EMG report 7/27/02

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her low back on _____. The MAXIMUS chiropractor reviewer indicated that the treating doctor set a plan of care on 9/3/03 lasting 6-8 weeks that was directed at restoring lost function and strength and decreasing pain for this patient. The MAXIMUS chiropractor reviewer noted that with documentation of improvement in the patient's care it is medically necessary to continue treatment. The MAXIMUS chiropractor reviewer indicated that after 8 weeks of care documentation of decreased pain and increased range of motion was noted. The MAXIMUS chiropractor reviewer explained that during the following two weeks of continued treatment from 11/3/03 through 11/12/03 the patient continued to show improvement both subjectively and objectively with the treatment rendered. The MAXIMUS chiropractor reviewer also explained that postoperatively the patient had not received rehabilitative treatment and therefore, because of the amount of deconditioning the patient required continued rehabilitative care. Therefore, the MAXIMUS chiropractor consultant concluded that the neuromuscular reeducation, therapeutic exercises, therapeutic activities, and manual therapy technique, from 11/3/03 – 11/12/03 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department